Table 6. Antiretroviral Regimens Recommended for Treatment of HIV-1 Infection in Antiretroviral-Naïve Patients

Regimens should be individualized based on the advantages and disadvantages of each combination such as pill burden, dosing frequency, toxicities, drug-drug interaction potential, co-morbid conditions, and level of plasma HIV RNA. Clinicians should refer to **Table 6** to review the pros and cons of different components of a regimen and to **Tables 10-12** for adverse effects and dosages of individual antiretroviral agents. Preferred regimens are in bold type; regimens are designated as "preferred" for use in treatment-naïve patients when clinical trial data suggest optimal and durable efficacy with acceptable tolerability and ease of use. Alternative regimens are those where clinical trial data show efficacy, but it is considered alternative because of disadvantages compared to the preferred agent, such as antiviral activity, durability, tolerability, drug interaction potential, or ease of use. In some cases, based on individual patient characteristics, a regimen listed as alternative in this table may actually be the preferred regimen for a selected patient. Clinicians initiating antiretroviral regimens in the HIV-1-infected pregnant patient should refer to "*Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States*" at **http://aidsinfo.nih.gov/guidelines/**.

	Regimens	No. of pills
Preferred Regimens NNRTI-based	**Efavirenz + (lamivudine or emtricitabine) + (zidovudine or tenofovir DF) (AII) –** [note: efavirenz is not recommended for use in 1st trimester of pregnancy or in women with high pregnancy potential*]	2-3
PI-based	**lopinavir/ritonavir (co-formulation) + (lamivudine or emtricitabine) + zidovudine (AII)**	6-7
Alternative Regimens NNRTI-based	**efavirenz** + (lamivudine or emtricitabine) + (abacavir or didanosine or stavudine) **(BII) –** [note: efavirenz is not recommended for use in 1st trimester of pregnancy or in women with high pregnancy potential*]	2-4
	nevirapine + (lamivudine or emtricitabine) + (zidovudine or stavudine or didanosine or abacavir or tenofovir) **(BII) -** [note: High incidence (11%) of symptomatic hepatic events was observed in women with pre-nevirapine $CD4^+$ T cell counts >250 cells/mm^3 and men with $CD4^+$ T cell counts >400 cells/mm^3 (6.3%). Nevirapine should not be initiated in these patients unless the benefit clearly outweighs the risk.]	3-6
PI-based	**atazanavir** + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or didanosine) or (tenofovir + ritonavir 100mg/d) **(BII)**	3-6
	fosamprenavir + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or tenofovir or didanosine) **(BII)**	5-8
	fosamprenavir/ritonavir† + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or tenofovir or didanosine) **(BII)**	5-8
	indinavir/ritonavir† + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or tenofovir or didanosine) **(BII)**	7-12
	lopinavir/ritonavir + (lamivudine or emtricitabine) + (stavudine or abacavir or tenofovir or didanosine) **(BII)**	5-8
	nelfinavir + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or tenofovir or didanosine) **(CII)**	5-8
	saquinavir (sgc, hgc, or tablets)ϕ **/ritonavir**† + (lamivudine or emtricitabine) + (zidovudine or stavudine or abacavir or tenofovir or didanosine) **(BII)**	7-15
3 NRTI-based	**abacavir** + zidovudine + lamivudine **- only when a preferred or an alternative NNRTI- or a PI-based regimen cannot or should not be used (CII)**	2

* Women with child bearing potential implies women who want to conceive or those who are not using effective contraception

† Low-dose (100–400 mg) ritonavir per day

ϕ sgc = soft gel capsule; hgc = hard gel capsule